Complementary medicine in Europe

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See editorial by Oh

This is the eighth in an intermittent series of articles looking at medical issues in Europe

Complementary or unconventional treatments are used by many doctors and other therapists throughout Europe. The major forms are acupuncture, homoeopathy, manual therapy or manipulation, and phytotherapy or herbal medicine. The relative popularity of therapies differs between countries, but public demand is strong and growing. Regulation of practitioners varies widely: in most countries only registered health professionals may practice, but in the United Kingdom practice is virtually unregulated. Germany and some Scandinavian countries have intermediate systems. Legal reforms are in progress in the Netherlands and the United Kingdom. European institutions are starting to influence the development of complementary medicine. Harmonisation of training and regulation of practitioners is the challenge for the future.

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To speak of "alternative" medicine is, as Pietroni has pointed out, like talking about foreigners—both terms are vaguely pejorative and refer to large, heterogeneous categories defined by what they are not rather than by what they are.[1] The analogy is apt: the current worldwide trend away from suspicion and hostility between "orthodox" and "alternative" medicine towards investigation, understanding, and consumer protection can be compared with the process by which Europeans have learnt to view each other as partners rather than foreigners. This shift in attitude is evident in the BMA's recent publication, *Complementary Medicine: New Approaches to Good Practice*,[2] and in the use of the term "complementary" rather than "alternative." We welcome this new spirit and believe it will benefit patients.

Even the term complementary medicine is not entirely satisfactory, lumping together as it does a wide range of methods with little in common except that they are outside the mainstream of medicine. The most accurate term is perhaps "unconventional therapeutic methods."

The public

Consumer surveys consistently show positive public attitudes to complementary medicine, with about 60% of the public in the Netherlands[3] and Belgium[4] declaring themselves ready to pay extra health insurance premiums for it and 74% of the British public favouring it being available on the NHS.[5] The use of various forms of complementary therapy is summarised in the table. These data are compiled from public opinion surveys between 1985 and 1992[3,4,6-12]; they should be interpreted with caution because of methodological differences and, more importantly, because of the somewhat arbitrary and variable definition of "alternative." For instance, manipulation seems to be relatively less popular and homoeopathy more popular in Belgium and France than in the United Kingdom. In Belgium and France, however, osteopaths and chiropractors cannot practise legally but doctors and physiotherapists commonly use similar manipulative methods. Manipulation, when used by a recognised health professional, may not be recognised as "alternative"—but homoeopathy will be considered alternative whoever prescribes it.[13] Such differences in legislation and perception may account for some of the apparent divergence.

Percentage of public reporting use of complementary medicine

Country	Any form of complementary medicine	Acupuncture	Homoeopathy	Manipulation (including osteopathy and chiropractic)	Phytotherapy or herbalism
Belgium	31	19	56	19	31
Denmark	23·2	12	28	23	ND
France	49	21	32	7	12
Germany	46	ND	ND	ND	ND
Netherlands	20	16	31	ND	ND
Sweden	25	12	15	48	ND
United Kingdom	26	16	16	36	24
United States	34	3	3	30	9

ND = data not available.

In countries for which statistics are available, complementary therapies are used by 20–50% of the population. The popularity of complementary medicine is growing rapidly. For instance, in 1981, 6·4% of the Dutch population attended a therapist or doctor providing complementary medicine, and this increased to 9·1% by 1985 and 15·7% in 1990.[14] In the United Kingdom the proportion of members of the Consumers Association who had visited a non-conventional practitioner in the preceding 12 months rose from one in seven in 1985 to almost one in four in 1991.[15] Homoeopathy is the most popular form of complementary therapy in France—its use rose from 16% of the population in 1982 to 29% in 1987 and 36% in 1992.[16]

There are some intriguing national idiosyncrasies—for example, reflexology is particularly popular in Denmark (39% of complementary medicine users). This relates to the legal situation: in 1981 the Danish High Court ruled that acupuncture is a form of surgery since it pierces the skin. Reflexology, which is related to acupuncture, does not. Anthroposophical medicine, inspired by the Austrian savant Rudolph Steiner, is particularly popular in German speaking countries; the Dutch are keen on spiritual healers, and massage is very popular in Finland.

Over the counter sales of homoeopathic medicines provide comparative data on the level of public demand for complementary medicine in the countries of the European Union (fig 1). The total European over the counter market for homoeopathy was £590m in 1991, compared with £1.45bn for herbal medicines. But doctors use homoeopathy more than herbs: in France, the world's largest market for homoeopathy, over 80% is dispensed on prescription rather than over the counter. The United Kingdom has among the lowest per capita spending in the European Union for over the counter homoeopathy, but the British market is growing by 20% a year. Other countries with low per capita spending have even more rapid growth—30% a year in Greece and Portugal.[17] The market for herbal medicines is also expanding: for instance, in Germany phytopharmaceuticals accounted for 7·7% of the total pharmaceutical market in 1985, and 10% in 1989.[11]

Practitioners

Direct comparisons of numbers and types of practitioners between countries, even within the European

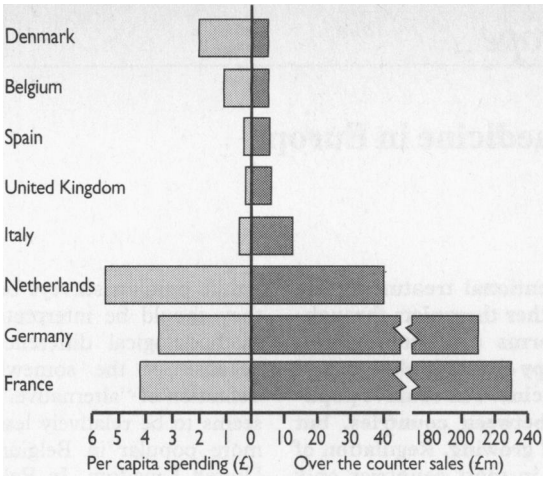

FIG 1—*The market for homoeopathic medicine in European countries, 1991*

Union, are impossible because of varying legal situations. In most member states of the European Union, including Belgium, France, Spain, Italy, and Greece, the practice of medicine, except by statutorily recognised health professionals, is illegal. This is also technically the situation in the Netherlands, but the Dutch government has stated that it will not prosecute non-medically qualified practitioners unless there has been malpractice. A comprehensive reform of the law governing medical practice in the Netherlands is under way. This will create a system of statutorily regulated registers and protected titles. In Denmark non-medically qualified practitioners may practise but the scope of their activities is restricted by law.

Germany has the unique Heilpraktiker (health practitioner) system. Originally introduced in 1939, it licenses practitioners who are not members of recognised health professions to practise provided they have passed an examination in basic medical knowledge and are registered. The system is administered by the Länder (provincial governments), and standards vary considerably between regions. Heilpraktikers are specifically prohibited from practising obstetrics, dentistry, and venereology. Non-medical psychotherapists are regulated by the same system.

In Great Britain and the Republic of Ireland there is no direct regulation of non-medically qualified practitioners: they can practise freely, subject to minor limitations imposed by various laws. For instance, they may not treat venereal disease or claim to be members of state registered health professions. It is illegal for unqualified people to practise dentistry or veterinary medicine. This unregulated situation has existed since the sixteenth century, but there has recently been a historic change: the osteopaths bill became law on 1 July 1993, establishing a statutory register, a governing council, and protection of title, making it illegal for anyone not on the register to describe themselves as an osteopath. Other therapies, notably chiropractic, may follow suit. The approach is broadly similar to that proposed, more systematically, in the Netherlands.

The General Osteopathic Council is only the second statutory complementary medicine body in the European Union. The only previously existing body was the United Kingdom's Faculty of Homoeopathy, which was incorporated by act of parliament in 1950 to train and examine doctors in homoeopathy. It also has an ethical function. Its remit has subsequently been extended to other recognised health professions, including veterinarians, dentists, pharmacists, and midwives. Britain is also the only European Union country to have complementary medicine hospitals in the public sector. There are five such NHS hospitals, in London, Glasgow, Liverpool, Bristol, and Tunbridge Wells.

EASTERN EUROPE

Information on eastern Europe is sketchier. In general the practice of medicine is restricted to recognised professions. In East Germany existing Heilpraktikers were allowed to continue in practice but no new ones were licensed. Bans on homoeopathy in Hungary, Czechoslovakia, and East Germany have been lifted since the fall of communism. In general, complementary medicine was not encouraged or incorporated in state systems, but it was not prohibited. Strong herbal and folk traditions persisted throughout eastern Europe. Towards the end of the communist period acupuncture was incorporated in some state health systems. Liberalisation of health care systems has led to an upsurge of interest in complementary therapies throughout eastern Europe.

Provision

Patterns of provision vary widely. A survey in the United Kingdom in 1980–1 suggested that there were 12·1 non-medically qualified practitioners per 100 000 population—27% of the number of general practitioners. The number of non-medically qualified practitioners was estimated to be growing by about 10% a year.[18] Most osteopaths, chiropractors, and acupuncturists but only a quarter of homoeopaths had some formal professional education. Public access to complementary medicine was overwhelmingly through non-medically qualified practitioners. The ratio of treatments by non-medically qualified practitioners to doctors was 12:1.[19] More recent evidence suggests growing interest in complementary therapies among general practitioners—surveys have shown 31-38% of general practitioners had received training in complementary therapies, with 15-42% wanting further training.[20,21] Interest is greater among younger doctors.[22]

By contrast, in Belgium 84% of homoeopathy and 74% of acupuncture is carried out by doctors, while manipulative treatment is divided equally between physiotherapists (33%) and non-medically qualified practitioners (34%).[4] In France manipulation is more commonly provided by physiotherapists than by osteopaths—2000-4000 physiotherapists use

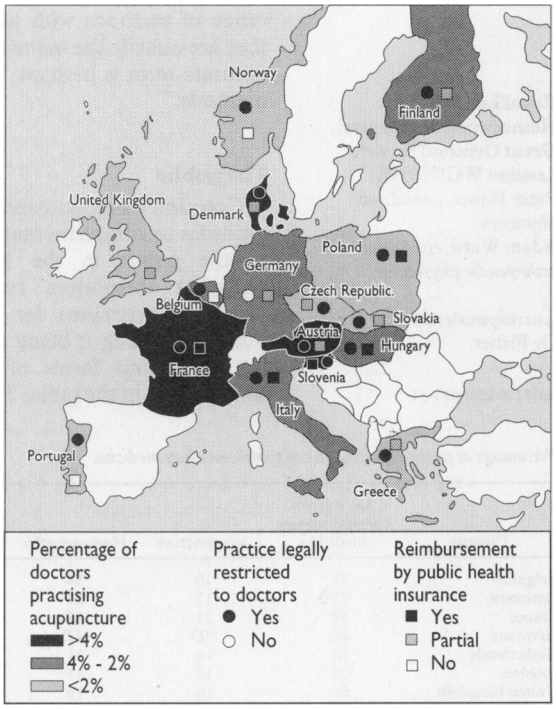

FIG 2—*Acupuncture in Europe: proportion of doctors practising; legal position of acupuncturists; reimbursement by public health insurance*[32]

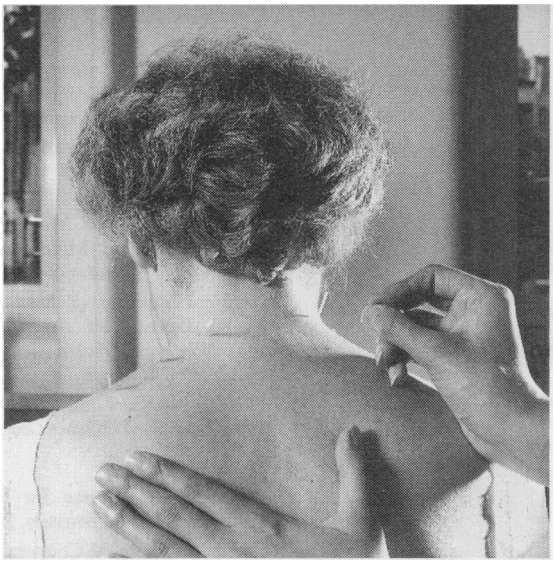

FIG 3—*Acupuncture is one of the most popular forms of complementary medicine throughout Europe*

complementary methods but there are only 150-300 osteopaths. Manipulation is also practised by specialist hospital doctors in many European countries. Over a third of France's 54 500 general practitioners use complementary methods: 5% exclusively, 21% often, and 73% occasionally.[8] The divergence is even sharper for herbal medicine (now often known as phytotherapy)—in most European countries it can legally be practised only by doctors, but in the United Kingdom practitioners are almost entirely non-medical.

In the Netherlands 47% of general practitioners use complementary therapeutic methods, most commonly homoeopathy (40%); 9% use manipulation and 4% acupuncture. Manipulation and acupuncture are more commonly used by health professionals other than doctors and by non-medically qualified practitioners.[3] In Germany 77% of pain clinics use acupuncture,[11] and up to 37% of British general practitioners use homoeopathy.[23] Those who use homoeopathy regularly do so in about a quarter of their consultations, the proportion being higher for hospital and private specialists.[24]

The attitudes of Dutch and British general practitioners who do not themselves use complementary methods are similar: 80% believe manipulation to be effective for neck and back problems. Among Dutch general practitioners, 50% consider acupuncture effective for chronic pain and 45% homoeopathy for upper respiratory tract infections and hayfever.[13] Three quarters of British fundholding general practitioners want complementary medicine available on the NHS, particularly osteopathy (88%), and also acupuncture, chiropractic, and homoeopathy.[25] Other forms of therapy such as reflexology and aromatherapy are in much less demand.

European institutions and research

On 1 January 1994 two European Council directives —on homoeopathic medicinal products and on homoeopathic veterinary medicinal products—came into force.[26,27] The directives are intended to ensure a single European market for these products. The provisions cover manufacture and inspection, marketing, and labelling. The most important provision is the establishment of a simplified registration procedure applying to medicines containing less than one part per 10 000 of the undiluted tincture or less than "1/100th of the smallest dose used in allopathy."

EC directive 65/65 on proprietary medicinal products has considerably constrained product licences for herbal medicines.[28] Concern at the possible carcinogenic effects of pyrolizidine alkaloids, which occur in a number of medicinal herbs, most importantly comfrey (*Symphytum officinale*), has recently prompted both the German and British governments to restrict the availability of these herbs. The case of comfrey highlights a regulatory problem—the plant is common in many European countries and is sometimes taken as a tea or vegetable: should it therefore be viewed as a food or as a medicine? This problem remains unresolved; the European Court of Justice has had to adjudicate on whether vitamins and herbal medicines are foods or medicines (cases 227/82 and 369/88).

COST project B4 is a European initiative for a comprehensive research programme in unconventional medicine. The governments of Denmark, Finland, Germany, Hungary, Italy, Norway, Slovenia, Spain, and the United Kingdom have joined Switzerland, the proposer of the programme. The project aims to demonstrate the possibilities, limitations, and significance of unconventional medicine; establish a common scientific background; and help in control of health care costs and harmonisation of legislation.

Some national governments also fund research in the area. The Dutch government has committed 1m guilders a year. In December 1992, the German federal ministry of research and technology advertised funding for research projects in unconventional medicine. This "Projekt Unkonventionelle Medizinische Richtung" has a budget of DM 10m and is coordinated by the University of Witten/Herdecke.

The future

The great challenge now is to harmonise systems of training and registration in Europe. Free movement of labour within the European Union is one of the keystones of the Treaty of Rome, but the diversity of national systems precludes this for practitioners of complementary therapeutic methods in the foreseeable future. Considering the case of a non-medically qualified acupuncturist practising in France (case No 61/89), the European Court of Justice upheld the right of member states to reserve the practice of the healing arts to doctors or not, in accordance with their own legislation. Such issues have been raised at the European parliament; in response the European Commission has stated that it is not planning any specific proposals in this area.[29]

In April 1994, however, the Committee on the Environment, Public Health, and Consumer Protection of the European parliament adopted a proposal on the status of complementary medicine. This called for provision of complementary medicine within social security systems, incorporation of complementary medicines in the European pharmacopeia, and a research budget of 10 million ecus (about £7·5m) a year for five years. It also demanded an end to prosecutions of non-medically qualified practitioners in countries such as France and Spain, and for a pan-European system of regulation of non-medically qualified practitioners along the lines of the British Osteopaths Bill. This proposal was to be debated by a full session of the European parliament on 6 May, but its opponents had it removed from the agenda on procedural grounds. Its sponsor, Belgian Green MEP Paul Lannoye, has vowed to revive it.

Present systems range from the tight regulation of France, Spain, Italy, and other countries to the virtually unregulated situation in the United Kingdom. We agree with the BMA's view (of the United Kingdom) that "the present situation, in which anybody is free to practise, irrespective of their training, is unacceptable."[2] But strict regulation also poses problems.

Many non-medically qualified practitioners practise outside the law, despite successful prosecutions, in

FIG 4—*Greater celandine* (Chelidonium majus), *a member of the poppy (Papaveraceae) family, is used by phytotherapists and homoeopaths for its effects on the biliary tract*

countries which restrict practice to members of recognised professions. Presumably, the very existence of such practitioners reflects public demand for their services. Another risk is illustrated by the osteopathic profession in America, which has been virtually assimilated into the conventional medical profession—so much so that calls are now being made for it to "return to its original mission."[30]

"Pluralism" is now in vogue, but this approach carries the risk of creating an overly complex Babel of minor professions. In a recent statement the Faculty of Homoeopathy divided complementary therapies into three groups: simple supportive treatments, such as massage; techniques with a specific application, such as osteopathy and chiropractic; and treatments such as herbalism, traditional Chinese medicine, and homoeopathy that can be applied across the whole spectrum of disease.[31] Different levels of regulation are appropriate for each category.

Familiarisation with non-conventional medicine is compulsory in the German medical curriculum and is included in the undergraduate course in several French and Dutch medical schools. The best established complementary medicine curriculum is the so called "Münchner Modell" developed at the medical faculty of the Ludwig Maximilian University, Munich. The BMA has recommended that complementary medicine should be incorporated into medical undergraduate curriculums and that accredited postgraduate training should be set up. This will ensure appropriate referrals and introduce these therapies to doctors who might go on to specialise in them. There is a risk in the BMA's proposals for regulation of imposing an unnecessarily bureaucratic system on doctors practising complementary therapies.

The interests of patients will best be served by a process of education, investigation, and regulation involving the public, doctors and health professionals, other practitioners, and national and European authorities.

We thank colleagues throughout Europe who have helped to collect data.

Organisations

Britain

British Medical Acupuncture Society, Newton House, Newton Lane, Warrington, Cheshire WA4 4JA (tel 0925 730727) Publishes *Acupuncture in Medicine*

Faculty of Homoeopathy, 2 Powis Place, Great Ormond Street, London WC1N 3HT (tel 071 837 2495; fax 071 278 7900) Publishes *British Homoeopathic Journal*

British Institute of Musculoskeletal Medicine, 27 Green Lane, Northwood, Middlesex HA6 2PX (tel 0923 835583) Copublishes *Journal of Orthopaedic Medicine*

National Institute of Medical Herbalists, 9 Palace Gate, Exeter, Devon EX1 1JA (tel 0392 426022) Publishes *European Journal of Herbal Medicine*

Research Council for Complementary Medicine, 60 Great Ormond Street, London WC1N 3JF (tel 071 833 8897; fax 071 278 7412) Publishes *Complementary Therapies in Medicine*

European

European Committee for Homoeopathy, 134 Boulevard Leopold II, B1080 Brussels, Belgium (fax +32 2 427 9446)

European Scientific Cooperative for Phytotherapy (ESCOP), de Weijert 8, NL7991 BP Dwingeloo, Netherlands

GIRI (International research group on very low dose effects), Laboratoire d'Immunologie, Faculté de Pharmacie, 15 Ave Charles Flahault, F34060 Montpellier Cedex 1, France (fax + 33 67 54 7533)

International Council of Medical Acupuncture and Related Techniques (ICMART), Rue de l'Amazone 62, B1050 Brussels, Belgium (fax +32 2 539 3692)

European Council of Doctors for Plurality in Medicine (ECPM), Ortenaustrasse 10, D76199 Karlsruhe, Germany (fax +49 721 88 62 78)

Projekt Unkonventionelle Medizinische Richtung, Universität Witten/Herdecke, Beckweg 4, D5804 Herdecke, Germany (fax +49 23 30 62 3995)

Projeckt Münchener Modell, Ludwig Maximilians Universität, Kaiserstrasse 8, D80801 Munich, Germany (fax +49 89 39 3484)

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Lesson of the Week

Value of opinion by oral physician in diagnosing Wegener's granulomatosis

J M Zakrzewska, J Feehally, J J H Gilkes

Adequate and appropriate oral biopsy by an oral physician may help diagnose potentially life threatening systemic disease

It has long been appreciated that the mouth is the mirror of the rest of the body. Many systemic diseases have oral symptoms, which often coincide with widespread evidence of disease. In some cases, however, oral symptoms may be the sole presenting sign of systemic disease. This may cause difficulty in diagnosis, yet little attention is paid to examination of the oral cavity in medical undergraduate training. It is therefore important that patients with oral lesions are referred to specialists in oral medicine for diagnosis, investigation, and management. We report on a patient in whom the diagnosis and treatment of a potentially life threatening systemic disease was delayed owing to poor appreciation of the clinical importance of oral lesions.

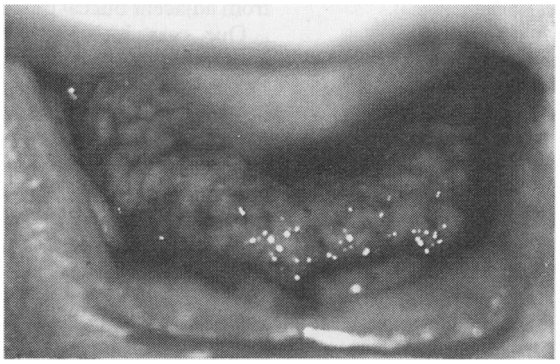

FIG 1—*Lower alveolar ridge at time of diagnosis showing hyperplastic granulomatous strawberry-like gingiva. Both ridges were affected and extremely painful*

Case report

A 53 year old woman presented with a history of bleeding gingiva. She had had ulcerative colitis for 12 years, which was controlled by sulphasalazine treatment. Her general dental practitioner had extracted all her remaining teeth on the assumption that her bleeding gingiva and mobile teeth were due to periodontal disease. No biopsy specimen was taken at this time. Dentures were made, but she could not tolerate them, and the gingiva continued to bleed.

She was next seen by an oral surgeon, who, in view of her history of ulcerative colitis, diagnosed pyostomatitis vegetans. An oral biopsy specimen showed non-specific chronic inflammation with hyperplasia and atypia. She was referred to an ear, nose, and throat surgeon, who gave laser treatment to the gingiva on three occasions. There was some response, but the symptoms recurred within a year, and she was then referred for a third opinion to an oral medicine department. By this time she had bleeding gums for three years; her dentures no longer fitted and caused profuse bleeding, as did any minor oral trauma. She could not eat and was losing weight. She had also had epistaxis and nasal obstruction for two years. She was taking only sulphasalazine and vitamin supplements.

Oral examination showed florid lesions affecting the whole of her upper and lower alveolar ridges with some extension into the buccal mucosa in the upper right premolar region. The tissue was red, hyperplastic, and granulomatous and covered with petechiae (fig 1). The appearances resembled a strawberry. She had similar lesions in her nose. The results of the rest of the physical examination were unremarkable, with no clinical evidence that the eyes, skin, joints, genitals, or kidneys were affected. A deep biopsy specimen was taken from the right buccal mucosa. Histology showed microabscesses with giant cells and granulomas. There was a granulomatous leucocytoclastic vasculitis with perivascular lymphocytes and polymorphs. Wegener's granulomatosis was diagnosed, and she was referred to a nephrologist for initiation and supervision of immunosuppressive treatment. Further investigation showed a normal chest radiograph and normal renal function (serum creatinine concentration 90 μmol/l). Urine testing for blood and protein gave negative results. Concentrations of C reactive protein were not raised, and indirect immunofluorescence for antibody to neutrophil cytoplasm gave negative results.

She was treated with oral enteric coated prednisolone 30 mg and cyclophosphamide 150 mg daily. Within two weeks she had less pain and bleeding and was able to eat without discomfort. After three months all her intraoral lesions had cleared and she was able to wear a new denture (fig 2). After 18 months treatment was withdrawn, and there has been no recurrence.

Discussion

Until the introduction of immunosuppressive treatment most patients with Wegener's granulomatosis died of their disease.

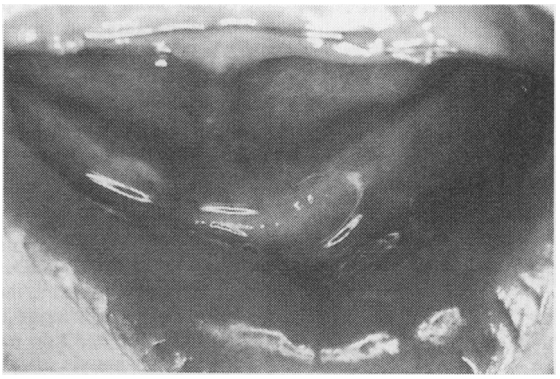

FIG 2—*Lower alveolar ridge six months after treatment showing normal mucosa taken as a mirror shot. Both ridges were free of lesions*

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